Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
IL6008874		B. WING _		10/14/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY	, STATE, ZIP CODE		
PRESEN	ICE SAINT BENEDIC	F N & R 6930 WE: NILES, IL	ST TOUHY	AVENUE		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations				
	300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a)		THE RESIDENCE OF THE PROPERTY			
	a) The facility shall procedures governi facility. The written per formulated by a Committee consisting administrator, the amedical advisory coof nursing and other policies shall comply The written policies the facility and shall	dvisory physician or the immittee, and representatives in services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually locumented by written, signed				
	Nursing and Person b) The facility shall pand services to attain practicable physical, well-being of the reseach resident's complan. Adequate and care and personal caresident to meet the care needs of the received	provide the necessary care in or maintain the highest mental, and psychological sident, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal sident.  Giving staff shall review and bout his or her residents		Attachment A Statement of Licensure Vic	olations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/10/15

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			COM		
IL6008874		B. WING		i	C		
12000014					1 10/	14/2015	
NAME	OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
PRE	SENCE SAINT BENEDIC	T N & R 6930 WE	ST TOUHY A 60714	VENUE			
(X4) PRE TA	FIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TON SHOULD BE	(X5) COMPLETE DATE	
			TAG	DEFICIENCE		DATE	
S9	999 Continued From pa	age 1	S9999				
	d) Pursuant to subs	section (a), general nursing	APPROVIDE AND ADDRESS OF THE APPROVIDE AND ADDRESS OF THE APPROVIDE ADDRESS OF THE APPROVINCE ADDRESS				
		at a minimum, the following	-				
	and shall be practic						
	seven-day-a-week	basis:	- Vid				
	6) All necessary pre	ecautions shall be taken to					
		idents' environment remains	VA T-MINE AND MINE AN				
		hazards as possible. All					
		shall evaluate residents to see	the state of the s				
	that each resident r	receives adequate supervision	Average and a second				
	and assistance to p	prevent accidents.	190,000				
	Section 300.3240 A	Abuse and Naglast	Description			!	
		ee, administrator, employee or	This Park a sur				
		nall not abuse or neglect a	to de pero, por				
	resident. (Section 2						
						- Indicate and the second	
	These findings were	e not med as evidence by:					
	Based on interview	and record review the facility	777				
	failed to have two st	taff members transfer a				,	
		d and ensure a nursing staff					
	(Z3) is trained regar						
	transferring a reside	ent. This applies to one of	de Arten (plan)				
	three residents (R2)	reviewed for injuries, in a	The state of the s				
		esult, R2 sustained a fractured	10, 10,000,000			:	
	humerus (arm bone	).	The state of the s			l	
	Findings Include:					\ !	
	On 10/8/15 at 1:00 p	om R2 stated that her				A COLUMN TO THE	
	shoulder was hurt w	hen someone was putting her					
	back to bed. R2 sta	ited the Certified Nursing					
		ked her up under her arms.					
	R2's progress note of	dated 8/22/15 indicated R2					
		ed after being lifted from the					
	chair to the bed.		¥				
	Dota material Co	, , , , , , , , , , , , , , , , , , , ,	Andrews in the				
	RZ's minimum date :	set assessment (MDS) dated					

XA6V11

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S999 Continued From page 2 8/09/15 includes diagnoses of arthritis and osteoporosis.  R2's incident report dated 8/21/15 indicates R2 complained of right shoulder pain when lifting arm. R2's incident report indicates that R2 had swelling of the whole right arm. R2's final investigation report dated 8/28/15 that R2's CNA transferred R2 from the chair to the bed without assistance from other staff and without the use of a mechanical lift. The report also indicates that all staff interview denied assisting Z3 (Agency CNA) getting R2 into bed.  R2's radiology report dated 8/22/15 indicates that R1 had a recent fracture involving the humeral neck with medial displacement.  On 10/14/15 at 3:49 pm E10, Registered Nurse (RN) stated Z3, Agency CNA carring for R2 was from an agency. E10 stated early in the evening Z3 informed her R2 had not been placed in the bed because R2 requires two person transfer assistance. E10 stated Z3 was informed to ask for help when placing R2 in the bed. E10 stated later in the shift Z3 reported R2 was placed in bed and was complaining of right shoulder pain. E10 stated Z3 was aware that R2 required two person transfer assistance.  R2's MDS dated 8/09/15 indicates R2 is total dependence requiring two or more person physical assistance. R2's MDS indicates R2's grange of motion is impaired on both sides for			- oparamone or a dono	1 / CG:G:					
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  83 WINST TOUTHY AVENUE  WILES, IL 60714  [KA1]D  [KA2]D  [KA2]D  [KA2]D  [KA2]D  [KA2]D  [KA2]D  [KA2]D  [KA3]D  [KA2]D  [KA3]D  [KA2]D  [KA3]D	AND PLAN OF CORRECTION IDENTIFICATION NUMBE							COMPLETED	
NAME OF PROVIDER OR SUPPLER  STREET ADDRESS, CITY, STATE, JP CODE  830 WEST TOUTH AVENUE  NILES, IL 60714  (K4) ID  (K4)									
PRESENCE SAINT BENEDICT N & R  930 WEST TOUHY AVENUE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRESENCE SAINT BENEDICT N & R  (X4) ID PREPRIVE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (PRESENCE ACTION SHOULD BE TAG (PREPRIVED BY FULL SPECIAL PROPERTY OF THE APPROPRIATE BEFFICIENCY)  S999 Continued From page 2  8/09/15 includes diagnoses of arthritis and osteoporosis.  R2's incident report dated 8/21/15 indicates R2 complained of right shoulder pain when lifting arm. R2's incident report indicates that R2 had swelling of the whole right arm. R2's final investigation report dated 8/28/15 that R2's CNA transferred R2 from the chair to the bed without assistance from other staff and without the use of a mechanical lift. The report also indicates that all staff interview denied assisting Z3 (Agency CNA) getting R2 into bed.  R2's radiology report dated 8/22/15 indicates that R1 had a recent fracture involving the humeral neck with medial displacement.  On 10/14/15 at 3.49 pm E10, Registered Nurse (RN) stated Z3, Agency CNA caring for R2 was from an agency. E10 stated early in the evening Z3 informed her R2 had not been placed in the bed because R2 requires two person transfer assistance. E10 stated Z3 was informed to ask for help when placing R2 in the bed. E10 stated later in the shift Z3 reported R2 was placed in bed and was complaining of right shoulder pain. E10 stated Z3 was aware that R2 required two person transfer assistance. R2's MDS indicates R2's pange of motion is impaired on both sides for			IL6008874	B. WING	nethorps were not askala ethe to the order of the top consoly for more askala en askala en la and a second	i i	-		
PRESENCE SAINT BENEDICT N & R    (X4)   D	NAN	AE OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE	minima de managare de la companya de		
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R2's falls care plan updated 8/20/15 includes an intervention for mechanical lift for transfer with two staff assist. R2's activities of daily living care			complained of right arm. R2's incident is swelling of the whole investigation report transferred R2 from assistance from oth a mechanical lift. The staff interview denied getting R2 into bed.  R2's radiology repore R1 had a recent fractineck with medial distribution of the properties of the properti	shoulder pain when lifting report indicates that R2 had e right arm. R2's final dated 8/28/15 that R2's CNA the chair to the bed without er staff and without the use of he report also indicates that all dassisting Z3 (Agency CNA) at dated 8/22/15 indicates that educe involving the humeral splacement.  In pm E10, Registered Nurse ency CNA caring for R2 was 0 stated early in the evening had not been placed in the quires two person transfer ated Z3 was informed to ask g R2 in the bed. E10 stated eported R2 was placed in bed g of right shoulder pain. E10 at that R2 required two person R2's MDS indicates R2 is total and the grade on both sides for remities. Updated 8/20/15 includes an manical lift for transfer with					

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					С	
		IL6008874	B. WING		10/	14/2015
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PRESEN	ICE SAINT BENEDICT	N&R 5930 WES	ST TOUHY A' 60714	VENUE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOUL (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF	JLD BE COMPLETE	
S9999	Continued From pa	ge 3	S9999			
	mechanical lift.					
	stated it is never ok lifting under the arm a mechanical lift for must be gentle and residents with fragile On 10/14/15 at 6:00 stated Z3 is an ager responsible for train the agency makes s facility are met before the agency sends C field.	pm E2, Director of Nursing ncy CNA and the agency is ing their staff. E2 stated that sure the requirements of the re sending a CNA. E2 stated NA's that are experts in the				
	movement dated 1/7 requires that any emincludes, or may includes, or may include reposition patients/residuse of patients/residuse of patients/residuse movement. The polishould utilize the prodevices, etc. to mate	icy also indicates that staff oper techniques, lifting the identified task and the void manual lifting unless				
		(B)				
			TO THE OWNER OF THE PROPERTY O			

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